

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10543

Registration District No. 22

Primary Registration District No. 57743

Registrar's No. 7

1. PLACE OF DEATH:

- (a) County Cape Girardeau
(b) City or town Tilsit
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Tilsit mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether

In this community entire life years, months or days)

3. (a) PRINT FULL NAME DR J W Ramsey 520

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Kathryn Ramsey 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased Dec 6 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 5 6 hr. min.

9. Birthplace Near Millersville mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Dr. M.D.

11. Industry or business

MOTHER FATHER { 12. Name Albert Ramsey
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Kathryn Barber
15. Birthplace Mo. Columbia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. W. Ramsey

(b) Address Burfordville Mo.

17. (a) Burial (b) Date thereof 3-14-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ramsey Cem.

18. (a) Signature of funeral director Crane W. Miller

(b) Address Jackson mo.

19. (a) 3/14/1940 (b) W. W. Ford
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Cape Girardeau

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Near Tilsit
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
year 1940 hour 6:00 minute PM

21. I hereby certify that I attended the deceased from Mar 1, 1940 to Mar 12, 1940

that I last saw him alive on Mar 12, 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration 10 min

Due to Q. W.

Due to

Other conditions Phlebitis from Rectum 5/11
(Include pregnancy within 5 months of death)

Major findings: ✓
Of operations

Of autopsy ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. W. Ford (M. D. or other) 1

Address Jackson mo Date signed 3-12-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed.....

Lymaw Steele

Licensed Embalmer No. *2476*

P. O. Address.....

Lachaw Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 10543
Registrar's No. 7

Registration District No. 12.6

Primary Registration District No. 5174 B

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Marionville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)
In this community years, months or days

3. (a) PRINT FULL NAME

Dr. John W. Ramsey

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

80

5

6

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) March 14
(Date received local registrar)

(b) Mrs. H. H. Ford
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. ? years

NEURAL CERTIFICATION

20. DATE OF DEATH Month Mar day 12 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature D. J. Leaburg (D. or other)

Address Jackson signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

S-10543

1940